Georgia Department of Community Health

SXC Health Solutions, Inc.

Atypical Antipsychotic Prior Authorization Form

Fee-for-Service Medicaid/PeachCare for Kids

PHONE #: 866-525-5827

FAX #: 888-491-9742

Note: If the following information is NOT filled in completely, correctly, or legibly the PA process **may** be delayed. **(One form per member please)**

MEMBER Last Name	**MEMBER First Name**
MEMBER ID number	**MEMBER Date of Birth** -- --
PRESCRIBER Last Name	**PRESCRIBER First Name**
PRESCRIBER NPI#	
PRESCRIBER Phone	**PRESCRIBER Fax**
PRESCRIBER Address	

Medication Requested:_____**Strength:**_____

Directions: _____**Dosage Form:** _____**Compound** ☐ **Y** ☐ **N**

What is the member's diagnosis?

☐ Bipolar Disorder ☐ Schizophrenia ☐ Schizoaffective Disorder
☐ Major Depressive Disorder ☐ Irritability associated with Autistic Disorder
☐ Other (specify): _____

****NOTE: Section A or B must be completed.****

CHECK ONE A OR B

☐ **A.** **The member has been established on the requested medication**

1. How long has the member been taking the requested medication?

   ☐ <2 weeks ☐ ≥2 weeks

2. Has the member shown improvement in symptoms while on the requested medication?
   ☐ Yes ☐ No
   If yes, please check one or more boxes below for areas of improvement: ___

   ☐ delusions ☐ excitement ☐ conceptual disorganization
   ☐ grandiosity ☐ hostility ☐ hallucinatory behavior
   ☐ suspiciousness/persecution ☐ blunted affect ☐ emotional withdrawal
   ☐ passive/apathetic social withdrawal ☐ poor rapport
   ☐ difficulty in abstract thinking ☐ lack of spontaneity and flow of conversation
   ☐ stereotyped thinking ☐ suicidal thoughts ☐ depressive symptoms
   ☐ other_____

☐ **B.** **The member has never taken the requested medication**

1. Does the member have an immediate family member (father, mother, brother or sister) who has been successfully treated on the same drug requested?
   ☐ Yes ☐ No ☐ Cannot Disclose

2. Which preferred medication(s) has the member tried? (check all that apply)
   ☐ Geodon Dates: _____ ☐ Risperidone Dates: _____
   ☐ Seroquel IR Dates: _____ ☐ None

3. Reason preferred agents are not appropriate for this member: (Complete for each drug in the following table)

Drug	Reason inappropriate choice for member
Risperidone	
Seroquel IR	
Geodon	

4. For Abilify and Seroquel XR (adjunctive therapy for major depressive disorder only): Reason antidepressant monotherapy is not adequate for this member: (Complete for each drug/class in the following table)

Drug	Reason antidepressant monotherapy is inadequate
Cymbalta (duloxetine)	
Effexor (venlafaxine)	
SSRIs (citalopram [Celexa], escitalopram [Lexapro], fluoxetine [Prozac], fluvoxamine [Luvox], paroxetine [Paxil], or sertraline [Zoloft])	

CHECK IF APPLICABLE

☐ **C. An orally disintegrating dosage formulation is being requested.**

1. What prevents the member from taking the regular oral dosage form?
   ☐ Dysphagia ☐ Compliance monitoring required
   ☐ Other (specify):_____

☐ **D. Risperdal Consta, Invega Sustenna, or Zyprexa Relprevv is being requested.**

1. Has the member tried oral risperidone or oral Invega (if Risperdal Consta is being requested), oral Invega, oral risperidone, or Risperdal Consta (if Invega Sustenna is being requested), or oral Zyprexa (if Zyprexa Relprevv is being requested) and is unable to swallow or use orally disintegrating tablets, or has been noncompliant after a trial of oral risperidone or oral Invega (if Risperdal Consta is being requested), oral Invega or oral risperidone (if Invega Sustenna is being requested), or oral Zyprexa (if Zyprexa Relprevv is being requested)?
   ☐ Yes Date of last therapy: _____ ☐ No

2. Is the prescribing physician a psychiatrist or has a psychiatrist been consulted?
   ☐ Yes ☐ No

3. Where will the medication be administered?
   ☐ Home health
   ☐ CSB (Community Service Board health center)
   ☐ Outpatient clinic or physician's office**
   ☐ Other (specify):_____

** If you are requesting for authorization for administration in a physician's office or outpatient clinic other than a CSB, please go to the Registered User portion of the Georgia Health Partnership website at www.ghp.georgia.gov to request a PA from Physician Services.

Physician Signature: _____

Contact Person:_____ **Phone:**_____

SXC Health Solutions, Inc. will provide a response within 1 business day upon receipt.